Utah State Hospital Policies and Procedures
Medical Staff ByLaws

13.1 Amendments
13.2 Adoption

Whereas Utah State Hospital is a psychiatric hospital organized under the laws of the State of Utah and under the administration of the Department of Human Services and the Division of Mental Health; and

Whereas Utah State Hospital is licensed to provide specialized psychiatric care, psychiatric and psychological evaluations and treatment for criminal offenders, and medical care for patients within the available resources; and

Whereas it is recognized that the medical staff is responsible for the care provided to all patients in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Department of Human Services and Division of Mental Health, and that the cooperative efforts of the medical staff, the Superintendent, and the Division of Mental Health are necessary to fulfill the hospital's obligation to its patients;

Therefore the physicians practicing within this hospital hereby organize themselves into a medical staff in conformity with the following bylaws.

UTAH STATE HOSPITAL

BYLAWS OF THE MEDICAL STAFF

The name of this organization shall be the Medical Staff of Utah State Hospital, hereinafter referred to as the medical staff.

"Governing Body" means the Superintendent of the Utah State Hospital, the Director of the Utah State Division of Mental Health, the Executive Director of the Utah State Department of Human Services, the Clinical Director of the Utah State Hospital, and the President of the Medical Staff of the Utah State Hospital.

"Hospital Clinical Director" (HCD) means that physician appointed by the Governing Body to be ultimately responsible to that body for all the clinical care provided at Utah State Hospital.

"Medical Executive Committee" (MEC) means a committee of the full medical staff.

"Medical Executive Committee Leadership Group" (MECLG) means a committee of leaders of the medical staff consisting of the Hospital Clinical Director; supervising physicians; and Medical Staff President, Immediate-Past President, and President-Elect.

"Clinical care" means services provided to patients by all health-care staff.
The pronouns his, he, or him, as used in these bylaws, refer to both male and female equally and without sexual prejudice.

The purpose of this organization shall be:

1. Provide to all patients admitted for treatment to each of the unit programs of the hospital quality medical and psychiatric care within available resources; and
2. Provide a competent level of performance of medical staff and hospital staff who provide clinical care through ongoing evaluation of care and improvement of clinical processes under the purview of the Quality Improvement program to insure that best practices are identified, taught, and implemented throughout the hospital; and
3. Provide an educational setting that maintains scientific standards and that promotes continuous advancement in medical/psychiatric knowledge and skills; and

4. Establish and maintain rules and regulations for self-government of the medical staff; and

5. Provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the HCD and the Hospital Superintendent; and

6. To assist in the education and training of other hospital personnel.

3.1 EXCLUSION

No practitioner is entitled to membership on the Medical Staff merely by virtue of the fact that he is duly licensed to practice his profession in this or any other state, or that he is a member of a professional organization, or that he has had in the past or presently has such privileges at another hospital.

3.2 GENERAL QUALIFICATIONS

Appointment to the medical staff confers only such prerogatives as specified in these bylaws and approved by the governing body in accordance with these bylaws.

Physicians and other practitioners shall be considered to possess basic qualifications for membership on the Medical Staff who:

3.2.1 Provide documentation of (1) current licensure; (2) adequate experience, education, and training; (3) current professional competence; (4) good judgment; and (5) adequate physical and mental health status to demonstrate to the satisfaction of the medical staff and the governing body that they are professionally and ethically competent, so that patients treated by them can reasonably expect to receive the generally recognized high professional level of quality care; (6) proof of malpractice insurance if not a merited State of Utah employee, i.e., a contract physician.

3.2.2 Are determined by current practice and credentials review to (1) adhere to the current standards of practice of their respective professions, (2) to work cooperatively with others in the hospital setting so as to maintain effective patient care, and (3) to participate in and properly discharge medical staff responsibilities; and

3.2.3 Meet the qualifications as established by the Utah State Department of Human Resource Management.

3.3 PARTICULAR QUALIFICATIONS

3.3.1 Physicians. A physician applicant for membership in the medical staff must hold an MD or DO degree issued by a medical or osteopathic school or college recognized by the State of Utah and must also hold a license to practice medicine issued by the State of Utah which is valid, current, and unsuspended.

3.3.2 Non-physicians. Non-physician membership on the medical staff is limited to dentists and podiatrists. They must be graduates of a professional school in their specialty that is recognized by the State of Utah, and they must be licensed by the State of Utah to practice

in their specialty as an independent practitioner.

3.4 RESPONSIBILITIES

The responsibilities of members of the medical staff (and other individuals with clinical privileges as applicable) include:

a. Provide quality patient care that meets generally recognized professional standards and that is achievable within the available resources and abide by accepted professional standards of practice.

b. Be aware of the general medical condition of patients for whom the member is responsible and refer management to an appropriately qualified physician as needed (applicable to psychiatrists).

c. Regardless of the staff status or specific clinical privileges, in case of emergency, provide any type of care necessary as a life-saving measure or to prevent serious harm provided that the care provided is within the scope of the individual's license. An emergency is defined as a condition wherein the life of the patient is in immediate danger or there is a serious threat to health and in which delay would increase the danger or threat.

d. Abide by the medical staff bylaws (as applicable to the member's profession); rules and regulations (applicable only to physicians, dentists, and podiatrists); and all other policies of the hospital.

e. Discharge in a responsible and cooperative manner committee assignments and other functions for which the member is responsible by virtue of appointment or election.

f. Prepare and complete in a timely manner clinical and other required records for all patients for whom the member provides care in the hospital.

g. Interview restrained or secluded patients face to face within one hour and complete PIRS notes within 24 hours. Sign all verbal orders within seven calendar days.

h. Arrange for care of his patients by a peer when the member is away from the hospital.

i. Abide by the provisions of Utah Code Annotated having to do with conflict of interest (a copy being provided each member.)

j. File with the medical staff coordinator a copy of current professional licensure and DEA certification.

k. Participate in the officer-of-the-day (OD) program as assigned by the HCD or designee to ensure that psychiatric and medical

coverage is available to patients.

l. Treat hospital patients and staff with dignity and respect.

m. Participate in at least twenty hours of continuing medical education programs per year.

n. Proctor new staff members as assigned by the HCD.

o. Provide input into the performance evaluations of the professional staff, and other staff as appropriate and necessary, in their service area and provide input into the performance evaluation of the administrative director, program director, and unit nursing director of their service area.

p. Discharge all other such staff obligations as may be required by the HCD.

3.5 APPLICATIONS

Application for membership in the medical staff organization may be made at the time of the employment interview. An application must be filled out by the applicant, and at least temporary privileges must be granted by the time actual employment at the hospital begins.

4.1 CATEGORIES OF MEMBERSHIP

4.1.1 ACTIVE STAFF

Qualifications

a. Employed at Utah State Hospital for 24 hours or more per week.

b. Meets qualifications set forth in Article III.

c. Completion of provisional probationary period as set forth in these bylaws in Section 7.4.

Prerogatives

a. Exercise such clinical privileges as are granted pursuant to Article VII.

b. Attend and vote on matters within the scope of his license that are presented at general and special meetings of the medical staff.

c. Hold office and serve as a voting member on committees to which he is duly appointed.

d. Proctor provisional members of the medical staff as assigned by the HCD. Proctor provides a bi-monthly written evaluation report to the credentials committee on each professional member proctored.

4.1.2 ASSOCIATE STAFF

The associate staff consists of practitioners who meet all requirements for active staff membership but who work less than 24 hours per week.

Prerogatives

a. Exercise such clinical privileges granted pursuant to Article VI.

b. May attend medical staff meetings, open committee meetings, and educational programs.

c. May not hold office in the organization but may serve on committees.

4.1.3 CONSULTING STAFF

The consulting staff consists of practitioners who meet all requirements set forth in Article III and who provide consulting services to the hospital on a contractual or fee-for-service basis.

Prerogatives

a. Exercise such clinical privileges granted pursuant to Article VII.

b. May attend medical staff meetings, open committee meetings, and educational programs.

c. May not hold office in the organization but may serve on committees.

4.1.4 PROVISIONAL STAFF

Qualifications

a. Meet the qualifications set forth in Article III.

b. Are within the probationary period (first twelve months) of their employment with the Utah State Hospital or have been given a one-year, rather than a two-year, reappointment to the medical staff.

c. Have a proctor assigned by the HCD (provisional staff members in the first twelve months of their employment with

the hospital). Consulting staff are not proctored.

Prerogatives

a. Exercise such clinical privileges as are granted pursuant to Article VII.

b. Attend general meetings of the medical staff, open committee meetings, and educational programs.

c. May not hold office in the medical staff organization but may serve on committees as assigned by the HCD.

Evaluation of Provisional Staff Members in the First Twelve Months of Employment

Thirty days prior to the completion of the twelve-month probationary period, the credentials committee reviews all pertinent information available on the staff member, including reports from the proctor, for the purpose of determining its recommendation concerning changing the staff status from provisional to active or associate. If the recommendation is to change the status, this occurs automatically, and there is no further action other than the applicant being informed of the change. Because applicants for active and associate status are also employees of the State of Utah, there is no provision for extending the provisional period beyond twelve months, as this would conflict with the twelve-month state-employee probationary period. Therefore, if the credentials committee recommends to not change the status, this is in fact a recommendation to terminate membership on the medical staff and clinical privileges. The recommendation is forwarded to the Medical Executive Committee Leadership Group (MECLG) for further action. If the MECLG recommends changing the status, this occurs automatically, and the member is informed. If the MECLG upholds the recommendation to terminate membership and privileges, a recommendation to this effect is forwarded to the Governing Body. If the Governing Body upholds the recommendation, the practitioner is informed of this and of his right to a due-process hearing.

4.1.5 <u>HOUSE STAFF</u>

Qualifications

a. Licensure as a physician in the State of Utah.

b. Referral from the University of Utah or other approved psychiatric residency or fellowship training program.

Prerogatives

a. Psychiatric residents assigned to Forensic Services

participate in competency evaluations and case staffing and provide psychiatric consultation under the supervision of a physician(s) who has been granted clinical privileges through the medical staff process.

b. Psychiatric residents assigned to Geriatric Services or Adult Services participate in case staffing and provide psychiatric consultation under the supervision of a physician(s) who has been granted clinical privileges through the medical staff process.

c. Child and adolescent residents participate in the assessment and treatment of patients, including treatment plan development; contacts with parents, guardians, and other agencies; individual, family, group, and medication therapy; and writing of patient-care orders under the supervision of a physician(s) who has been granted clinical privileges through the medical staff process.

d. House staff practice within the scope of delineated clinical privileges of their physician supervisor(s).

e. House staff may attend general meetings of the medical staff, open committee meetings, and educational programs.

f. House staff may not vote on issues brought before the medical staff nor hold office in the medical staff organization.

g. Properly supervised house staff may provide emergency care as described under Article 3.4.c. of these bylaws.

4.2 LIMITATIONS OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and are subject to the limitations of clinical privileges which may be granted by special conditions attached to a particular membership, by other sections of these bylaws, or by the rules and regulations.

4.3 MODIFICATION OF STAFF CATEGORY

Changes in the staff category of a practitioner are made in accordance with these bylaws.

5.1 Nurse practitioners and optometrists are granted privileges through the Med. Exec. Committee Leadership Group (MECLG) and Governing Body but are not appointed to the medical staff.

5.1.1 Nurse practitioners may be granted the privilege to perform medical histories and physical examinations. When such individuals perform admitting and/or annual medical histories and physical examinations, their findings and conclusions are endorsed by a qualified physician member of the Medical Services staff within fourteen days.

5.1.2 At least two nurse practitioners serve as the Nurse Practitioner Credentialing Committee for the purpose of reviewing credentials files and making recommendations to the MECLG regarding clinical privileges for nurse practitioner applicants. Because of the limited size of the optometry staff, the Medical Staff Credentials Committees reviews credentials files and makes recommendations to the MECLG regarding clinical privileges for optometrist applicants.

5.1.3 The procedures outlined for appointment and reappointment of medical staff members in Article VI of these bylaws are followed for initial granting and renewing of cllinical privileges for nurse practitioners and optometrists.

6.1 APPOINTMENT AUTHORITY

Initial Appointments. Appointments and revocations of appointments are made by the governing body. Applicants are appointed to the medical staff in accordance with position specifications as defined by the State Department of Human Resource Management.

6.2 DURATION OF APPOINTMENTS

Except as otherwise provided in these bylaws, appointments to the medical staff are for a period of two years. Medical staff membership is automatically terminated at the termination of employment with the hospital.

6.3 APPLICATION FOR MEMBERSHIP

Application for membership on the medical staff is made in writing. The applicant has the burden of producing adequate information and documentation for proper evaluation of his competence, character, ability to perform required duties with or without accommodation, and other qualifications, and for resolving doubts about qualifications.

The application includes information regarding challenges to any licensure or registration or voluntary or involuntary relinquishment of such; voluntary or involuntary termination of medical staff membership; voluntary or involuntary limitation, reduction, or loss of clinical privileges; and involvement in professional liability action including final judgments and settlements.

By applying for appointment, an applicant thereby signifies his willingness to appear for interviews in regard to his application and authorizes the hospital to consult with members of the medical staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his competence. He also consents to the hospital's inspection of records and documents that may be material to the evaluation of his professional qualifications and competence to carry out the clinical privileges he requests. He releases from liability individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence and other qualifications for staff appointment and clinical privileges, including other privileged and confidential information.

The applicant submits a request in writing for specific privileges with the application for membership. To ensure that the individual requesting privileges is in fact the same individual who is identified in the credentialing documents, the applicant submits a copy of his driver's license. This requirement may be waived if the applicant is personally

known to a member of the medical staff or other licensed independent practitioner with clinical privileges at the Utah State Hospital.

The Medical Staff Coordinator requests peer recommendations in writing from the references and prior places of employment/practice listed on the application and submits a query to the National Practitioner Data Bank regarding the applicant. The Medical Staff Coordinator verifies licensure with the primary source at the time of appointment and initial granting of clinical privileges, at reappointment and renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate state licensing board or from any state licensing board if in a federal service. Current licensure may also be verified through the primary source Internet site or by telephone. This verification is documented. The peer recommendations, Data Bank printout, and licensure verification are considered in the appointment and privileging process.

The Medical Staff Coordinator submits the complete application to the Hospital Clinical Director as needed and then to the Credentials Committee for evaluation.

6.3.1 Confidentiality, Immunity, and Release

6.3.1.1 Authorization and Conditions

By applying for or exercising clinical privileges within this hospital, an applicant:

a. Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.

b. Authorizes persons and organizations to provide information concerning such applicant to the medical staff.

c. Agrees to be bound by the provisions of this Article and to waive legal claims against representatives of the medical staff or hospital who act in accordance with the provisions of this article.

d. Acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and the exercise of clinical privileges at this hospital.

6.3.1.2 Confidentiality of Information

a. General. Medical staff, service, or committee minutes, files, and records, including information regarding members or applicants to this medical staff, are, to the extent permitted by law, confidential.

Dissemination of such information and records takes place only where required by law, pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee Leadership Group or its designee, the HCD.

b. Breach of Confidentiality. Inasmuch as effective focused practitioner review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff meetings or committees, except in conjunction with another hospital, professional society, or licensing agency, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Med. Exec. Committee Leadership Group may undertake such corrective action as it deems appropriate.

6.3.1.3 Immunity from Liability

a. For Action Taken. Representatives of the medical staff and the hospital are exempt, to the extent permitted by law, from liability to an applicant or member for damages or other relief for actions taken or statements or recommendations made within the scope of their duties as a representative of the medical staff.

b. For Providing Information. Representatives of the medical staff and hospital and third parties are exempt, to the extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is or has been an applicant to or member of the staff who did or does

exercise clinical privileges or provide services at this hospital.

6.3.1.4 Activities and Information Covered

The confidentiality and immunity provided by this Article apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning but not limited to:

a. Applications for appointment, reappointment, or clinical privileges;

b. Corrective action;

c. Hearings and appellate reviews;

d. Utilization reviews;

e. Other service, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

f. Peer review organizations.

6.3.1.5 Releases

Applicants or members may, upon request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases is in accordance with the express provisions and general intent of this Article. Execution of such releases is not deemed a prerequisite to the effectiveness of this Article.

6.4 TIMELY PROCESSING OF APPLICATIONS

Complete applications for appointment are acted on within ninety days. A complete application is one for which all necessary information and documentation has been submitted and verified. If it is necessary for an applicant to begin their employment with the hospital before all information on the application can be verified, the applicant may be granted temporary privileges as provided under Section 7.6 of these bylaws. The application is acted on by the credentials committee no later than thirty calendar days prior to expiration of temporary privileges and is acted on by the Med. Exec. Committee Leadership Group prior to expiration of temporary privileges. If the applicant does not make their application complete by providing all necessary information and

documentation within ninety days of the original date of signature on the application form, the application is deemed to be withdrawn, and the credentialing process is terminated.

6.5 CREDENTIALING COMMITTEE STRUCTURE/RESPONSIBILITY

6.5.1 The Credentials Committee, composed of two psychiatrists and one physician from Medical Services as appointed by the HCD, is responsible for recommending action concerning credentialing and privileging of physicians. The committee reviews and appraises, at specified intervals, the quality and appropriateness of patient care and the clinical performance of each member.

6.5.2 Reports and recommendations from each professional staff are forwarded to the Med. Exec. Committee Leadership Group.

6.6 CREDENTIALS COMMITTEE ACTION

The appropriate credentials committee reviews the complete application and evaluates the supporting documents and other relevant information. A complete application is one on which all credentials have been verified by the Medical Staff Coordinator. The committee and other hospital staff, as appropriate, may interview the applicant and may seek additional information.

The committee immediately forwards to the Med. Exec. Committee Leadership Group, via minutes of the meeting in which the application and credentials are reviewed, a recommendation for:

a. Provisional appointment to the medical staff, or

b. Deferral of the decision on the application pending further information, or

c. Rejection of the application.

6.6.1 Favorable Recommendation

Recommendation for appointment includes recommendations for privileges to be granted and is indicated by the signature of a member of the credentials committee on the application.

6.6.2 Deferred Recommendation

Recommendation for deferral of the application for further consideration is followed within thirty days with a subsequent recommendation for provisional appointment with specified privileges or for rejection for specified reasons.

6.6.3 Adverse Recommendation

When the recommendation is adverse, in respect to appointment or privileges requested, such information is forwarded to the Med. Exec. Committee Leadership Group with specified reasons for rejection.

6.7 MEDICAL EXECUTIVE COMMITTEE LEADERSHIP GROUP ACTION

The Medical Executive Committee Leadership Group considers applications for appointment in their next regularly scheduled meeting following the forwarding of a recommendation from the credentials committee. The Med. Exec. Comm. Leadership Group forwards to the Governing Body, a recommendation regarding appointment.

If appointment is recommended, the recommendation includes membership category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation are stated.

6.8 ACTION BY THE GOVERNING BODY

The Governing Body may accept the recommendation of the Medical Executive Committee Leadership Group (MECLG) or may refer it back to the MECLG for further consideration, stating the reasons for such action. Action is taken by the Governing Body at the next regularly scheduled meeting of the Governing Body following receipt of the MECLG's recommendation. The Governing Body, pursuant to its bylaws, may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to a committee of the Governing Body.

6.9 REAPPOINTMENTS

Each member is considered for reappointment and redetermination of privileges by the credentials committee no less often than every two years. All pertinent information is reviewed.

a. At least ninety days prior to the expiration date of the current staff appointment, the medical staff coordinator mails or delivers to the member a reapplication form. Failure to return the application within thirty days of receipt constitutes voluntary resignation from the medical staff.

b. The medical staff of Utah State Hospital is non-departmentalized and consists of psychiatrists, internists, family practitioners, pediatricians, dentists, neurologists, podiatrists, and radiologists. The medical staff coordinator requests a reappointment recommendation from the applicant's supervising psychiatrist for all psychiatrists applying for reappointment, from the Hospital Clinical

Director the Director of Medical Services or a supervising psychiatrist applies for reappointment, from the President of Medical Staff when the Hospital Clinical Director applies for reappointment; and from the Director of Medical Services for all internists, family practitioners, pediatricians, dentists, neurologists, podiatrists, and radiologists applying for reappointment. At least two peer recommendations for reappointment are also requested for active and associate staff members adn for consultants who have peers on staff. Arrangements are made with an outside specialist to provide peer review and recommendation for reappointment for consultants who do not have peers on staff.

c. The medical staff coordinator queries the National Practitioner Data Bank regarding members requesting renewal of privileges. The Data Bank printout is considered in the evaluation for reappointment and renewal of privileges.

d. The Medical Staff coordinator prepares a performance profile for the past two years on active and associate staff members that includes confirmation of adherence to medical staff membership requirements stated in medical staff bylaws; rules and regulations; and policies; relevant practitioner-specific information from organization performance activities; and any results of peer review of the individual's clinical performance.

e. The Medical Staff Coordinator verifies current licensure with the primary source as described under 6.3.

f. The Credentials Committee, at least thirty calendar days prior to the expiration of a member's present appointment, reviews the materials that have been collected by the medical staff coordinator. Relevant practitioner-specific information from organization performance-improvement activities is considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills. Any results of peer review of the individual's clinical performance are also considered. The Credentials Committee submits a reappointment recommendation to the MECLG.

g. Prior to the expiration of a member's present appointment, the MECLG reviews the materials collected by the medical staff coordinator. Relevant practitioner-specific information from organization performance-improvement activities is considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills. Any results of peer review of the individual's clinical performance are also

considered. MECLG forwards a reappointment recommendation to the Governing Body.

h. Applicants for reappointment and renewal of clinical privileges are required to submit any reasonable evidence of current health status that may be requested by the MECLG.

i. Results of QI activities are considered in the evaluation for reappointment. These include but are not limited to timely and accurate completion of medical records, attendance at meetings, committee service, and patterns of care. Consideration is given to the applicant's involvement in previous successfully or currently pending challenges to any licensure or registration in the last two years, voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at any hospital in the past two years, and involvement in professional liability action in the past two years and the final judgment(s) or settlement(s).

6.10 ONE-YEAR REAPPOINTMENT

Reappointment is normally for a period of two years. However, if the applicant member does not meet attendance or charting requirements or otherwise fails to adhere to the medical staff bylaws or rules and regulations, they may be reappointed for a period of one year. During this time their status is provisional, and they may not hold office int he medical staff organization. If the applicant fails to demonstrate improvement during this period of time, he is invited to meet with the MECLG to present a plan regarding what will be done to improve meeting attendance, charting, or other problems of adherence to the medical staff bylaws and rules and regulations and may be given a three-month appointment in which he is expected to carry out the stated plan. If the clinical privileges are denied, curtailed, suspended, or revoked at the completion of the three-month period, this is carried out in accordance with Article VIII, and the member is informed that he is entitled to the fair hearing and appellate review process provided by Article IX of these bylaws.

7.1 ADMITTING PRIVILEGES

Only medical staff members may be granted the privilege of admitting patients to the hospital.

7.2 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, members of the medical staff, nurse practitioners, and optometrists providing clinical services at this hospital are entitled to exercise only those clinical privileges specifically granted. Said privileges and services are hospital-specific; within the scope of licensure, certification, or other legal credential authorizing him to practice in this state; and consistent with the restrictions thereon.

In carrying out their professional duties, members of the medical staff, nurse practitioners, and optometrists are responsible to the Hospital Clinical Director. They are also subject to the hospital medical staff organization bylaws and rules and regulations.

7.3 DELINEATION OF PRIVILEGES IN GENERAL

7.3.1 Requests

Applications for appointment and reappointment are accompanied by a request form for specific privileges.

Initial recommendation for clinical privileges is made by the appropriate credentials committee at the time of the appointment and no less often than every two years thereafter.

7.3.2 Basis for Privilege Determination

Requests for clinical privileges are evaluated on the basis of the member's education, training, experience, demonstrated competence, judgment, health status, clinical performance, and the documented results of patient care and other quality review monitoring.

Privilege determination may also be based on pertinent information obtained from other institutions and healthcare settings where the member has exercised privileges.

The scope and extent of the procedures which may be performed are specifically delineated. Conclusions are arrived at only on the basis of verified information.

Individuals contracted by the hospital to provide patient care

services have their clinical privileges delineated in the same manner as all other members of the medical staff as described in this article.

In order to ensure that medical staff members only exercise privileges as granted, the medical staff coordinator provides to staff, who work with individuals with delineated clinical privileges, a list of those privileges.

7.4 PROCTORING AND COMMITTEE ACTIONS

New physician appointees are subject to a period of proctoring for the duration of their provisional period or their first twelve months on the medical staff. The Hospital Clinical Director assigns a proctor. The Medical Staff Coordinator requests the first report from the proctor for inclusion in the appointee's credentials file sixty days after the new member is appointed to the position.

The Medical Staff Coordinator subsequently requests bi-monthly reports from the proctor for inclusion in the new member's credentials file. These reports include an evaluation of appropriateness of and indication for drug use, timely completion of records, appropriate reflection of the patient's progress in the medical record, timeliness of requests for consultation if indicated, interaction with the medical staff and other professional staff, and the proctor's overall impression of the quality of care provided by the practitioner.

The Medical Staff Coordinator reviews each report and reports to the Hospital Clinical Director any unfavorable information. The Hospital Clinical Director reviews this with the new member or assigns the proctor to review it with the new member. Unresolved issues are reviewed by the Medical Staff Credentials Committee which makes a recommendation to the MECLG concerning action to be taken. Thirty days prior to completion of the new member's twelve-month provisional status, the Medical Staff Credentials Committee reviews all proctoring reports for the purpose of recommending whether the member's provisional status should be changed (to active, associate, or consultant).

7.5 Denial, curtailment, suspension, or revocation of clinical privileges shall be carried out according to these bylaws. See 4.3.4 (Evaluation of Provisional Staff Members in First Twelve Months of Employment) and Article VIII.

7.6 TEMPORARY PRIVILEGES

Temporary privileges may be granted for a period of up to 120 days when the new applicant for medical staff membership or privileges is waiting for a review and recommendation by the medical staff executive

committee leadership group and approval by the governing body. The Superintendent or designee may grant temporary privileges upon recommendationn of the Hospital Clinical Director, if

7.6.1 There is verification (which may be accomplished through a telephone call) of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested;

7.6.2 The results of the National Practitioner Data Bank query have been obtained and evaluated; and

7.6.3 The applicant has a complete application, no current or previously successful challenge to licensure or registration, has not been subject to involuntary termination of medical staff membership at another organization, and has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

7.6.4 Temporary emergency privileges for existing medical staff members with clinical privileges, including properly supervised members of the house staff, are described under article 3.4.c of these bylaws.

7.6.5 Disaster privileges may be granted by the superintendent or hospital clinical director of his or her designee(s) on a case-by-case basis at the discretion nof the responsible individual(s) when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs. Applicants for or individuals with disaster privilges report to the Director of Medical Services or his/her designee(s), indicate their medical specialty, and are assigned duties as a member of a medical services team. Concerns regarding the activities of individuals who receive disaster privileges are reported to the Director of Medical Services or his/her designee(s). The verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control and is identical to the process described above for granting temporary privileges. The superintendent or hopsital clinical director or his or her designee(s) may grant disaster privileges upon presentation of any of the following: a current picture hospital ID card; a current license to practice and a valid picture ID issued by a state, federal, or regulatory agency; identification indicating that the individual is a member of a disaster medical assistance team; identification indicating that the individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity; presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

8.1 EDUCATION

A CME activity for the medical staff and other organization staff regarding illness and impairment recognition issues specific to physicians is planned and carried out by the CME Committee bi-annually.

8.2 SELF-REFERRAL AND REFERRAL BY OTHER ORGANIZATION STAFF

Impaired physicians are encouraged to self-report. Self-reported problems such as substance abuse and mental illness are handled confidentially. Confidentiality is minimal if patient harm has occurred because of the suspected impairment or if the individual has been disciplined previously by the hospital or by the licensing authority.

Other organization staff must report questions regarding competence or impairment to their supervisor who then reports to the Hospital Clinical Director (HCD) or appropriate supervising physician. Issues requiring corrective and/or disciplinary action will be handled in accordance with Article IX of these bylaws.

8.3 REFERRAL TO APPROPRIATE RESOURCES FOR DIAGNOSIS AND TREATMENT

The hospital administration will assist, as needed, a physician who has been identified as impaired in finding internal or external resources for diagnosis and treatment of the condition or concern.

8.4 MAINTENANCE OF CONFIDENTIALITY

The confidentiality of a physician seeking referral or referred for assistance is maintained except as limited by law, ethnical obligation, or when the safety of a patient is threatened.

8.5 EVALUATION OF CREDIBILITY OF COMPLAINT, ALLEGATION, OR CONCERN

Anonymous complaints are dismissed. An investigation of other complaints and interview of involved persons and witnesses is carried out by the Credentials Committee. Results are reported to the Med. Exec. Committee Leadership Group (MECLG). An administrative decision is made as to whether there is credibility. If a complaint may have merit, it is reported to the investigations unit of the Division of Occupational and Professional Licensing.

8.6 MONITORING OF THE AFFECTED PHYSICIAN

In order to protect the safety of patients until rehabilitation or any disciplinary process is completed, the hospital and the involved practitioner enter into a written contract which specifies the conditions under which the individual is allowed to work. The contract may specify allowing search of personal property, lockers, etc.; urinalyses on demand; possible peer monitoring or mentoring arrangements; and frequent random records reviews, etc. If the individual has met the criteria for entering the Utah Recovery Assistance Program, he must meet the conditions of the "Diversion Agreement" with URAP. The hospital obtains a signed release of information from the involved practitioner allowing URAP to report back to the hospital any lapses or problems.

8.7 REPORTING OF INSTANCES OF UNSAFE TREATMENT

Instances in which a physician is providing unsafe treatment must be reported to the medical staff leadership as described under 8.2 and 8.6 of this Article.

9.1 PROCEDURE

9.1.1 Practitioner conduct considered to not meet the standards of the hospital will be reported to the Hospital Clinical Director (HCD) or area supervising physician.

9.1.2 Issues involving practitioners which require corrective and/or disciplinary action will be handled by the HCD or area supervising physician in accordance with the USHOPP manual, Human Resources Chapter, Sections 2-4.

9.1.3 A practitioner for whom corrective action has been suggested may have an interview with the HCD. This interview is preliminary in nature and shall not constitute a formal hearing. Any hospital employee may initiate a grievance. Utah State Department of Human Resource Management rules are followed.

9.1.4 Corrective and disciplinary actions not affecting the practitioner's clinical privileges are confidential and are not to be discussed outside of the supervisor-employee relationship, except as provided for in 9.1.5 and 9.1.6 below.

9.1.5 The Medical Executive Committee Leadership Group (MECLG) may be petitioned by the employee to give an opinion regarding a corrective or disciplinary action.

9.1.6 When petitioned by the employee, the MECLG reviews all relevant facts and renders its findings and opinion to the HCD and referent member.

9.2 CORRECTIVE AND DISCIPLINARY ACTIONS REQUIRING FOCUSED PRACTITIONER REVIEW AND AFFECTING CLINICAL PRIVILEGES

9.2.1 If in the process of evaluating a complaint or reviewing the findings of the assessment of patient care processes, it appears to the HCD that there may be a need to limit a practitioner's clinical privileges, the HCD will promptly notify the MECLG after which the HCD will call the Medical Staff Credentials Committee into session and charge them with forucsed practitioner review of the practitioner in question.

9.2.2 The Credentials Committee will conduct its focused practitioner review and issue a report with recommendations to the HCD within thirty calendar days. The Credentials Committee will maintain strict confidentiality throughout the process. Minutes are kept within the committee and may only be forwarded to the MECLG.

9.2.3 If it is the decision of the credentials committee to make a recommendation which may limit clinical privileges, a report is submitted to the MECLG which considers it no later than the next regularly scheduled meeting. Such report shall:

a. Contain a summary of the complaint, the investigation, and the findings.

b. Contain the recommendation of the credentials committee.

9.2.4 The MECLG votes whether to accept, modify, or reject the recommendation of the credentials committee. The referent member receives a summary of the findings of the MECLG.

9.2.5 If the MECLG action consists of or includes a recommendation for a reduction or loss of clinical privileges, the referent practitioner may request an appearance before the MECLG for the purpose of an interview prior to the recommendation being forwarded to the Superintendent. This interview does not constitute a formal hearing, and none of the procedural rules with respect to hearings apply thereto, except that a detailed record of such interview is arranged for by the HCD. The referent practitioner has a right to legal counsel.

9.2.6 The Superintendent and the MECLG jointly confer on the appropriate action to be taken in regard to the referent practitioner, including appointing an external peer reviewer if there is conflict of interest with internal reviewers. External review may also be requested by the referent practitioner. There must be mutual agreement as to who performs the external review.

9.2.7 If the Superintendent finds that restriction or revocation of clinical privileges should be pursued, he will refer the matter to the Hospital Governing Body for their action.

9.2.8 Notification of the Governing Body's decision is made to the referent practitioner by first-class mail with a return receipt requested and a copy to the MECLG.

9.2.9 The Medical Staff Coordinator complies with current regulations for notifying external authorities such as law enforcement or the Division of Occupational and Professional Licensing at the required time and under the required circumstances.

9.3 APPEAL MECHANISMS

Any decision of the hospital administration to implement dismissal, demotion, disciplinary action, or corrective action entitles the referent practitioner to the appeal mechanism provided by Article IX of these Bylaws.

9.4 AUTOMATIC SUSPENSION

Actions by state licensing boards that revoke or suspend a practitioner's license automatically suspend his clinical privileges.

Failure of a practitioner to renew his license(s), certificate, or other legal credential prior to the expiration date automatically results in the suspension of clinical privileges.

Action by the USH Governing Body to suspend a practitioner's clinical privileges automatically results in dismissal as a Utah State Hospital employee.

9.5 SUMMARY SUSPENSION

The Superintendent or HCD has the authority, whenever action must be taken immediately in the best interest of patient care within the hospital, to summarily revoke or suspend all or any portion of a practitioner's clinical privileges and/or membership, and such summary suspension becomes effective immediately upon imposition.

Following such an administrative action, the HCD will refer the matter to the MECLG and credentials committee with subsequent review by the governing body.

10.1 NOTICE OF RIGHT TO HEARING

10.1.1 Any decision by the Governing Body to deny staff appointment or reappointment; suspend or terminate staff appointment; reduce staff category; fail to advance from provisional status; deny requested clinical privileges; reduce, suspend, or revoke clinical privileges; or impose a consultation or concurrent supervision requirement, except during a provisional period, entitles the practitioner to a hearing.

10.1.2 The process for fair hearing and appeal is the same for all medical staff members. Individuals with clinical privileges who are not members of the medical staff are afforded a fair hearing and appeal process.

10.1.3 The process for fair hearing and appeal does not apply to individuals holding temporary privileges.

10.1.4 The practitioner is advised of his rights to a hearing at the time of notification of the Governing Body's decision as described under 8.2.8. The notice to the practitioner indicates:

10.1.4.1 that a written request for a hearing must be received by the Superintendent within thirty days of receipt of the notice;

10.1.4.2 that failure to request a hearing within the specified time period constitutes a waiver of rights to a hearing, appellate review, or any other review of the matter; and

10.1.4.3 that upon receipt of the practitioner's request for a hearing, the Superintendent will notify the practitioner of the date, time, and place of the hearing.

10.2 NOTICE OF SCHEDULING OF HEARING

10.2.1 Within 45 days after receipt of a request for a hearing, the Superintendent schedules and arranges for such a hearing and notifies the practitioner of the date, time, and place of the hearing. The hearing date shall not be less than thirty days from the date of this notice to the practitioner.

10.2.2 The notice of hearing includes a list of witnesses expected to testify in support of the adverse recommendation. The notice also advises the practitioner that, at least fifteen days before the hearing, the practitioner shall be required to forward to the Superintendent a written list of witnesses the practitioner expects to present to testify against the adverse recommendation. The

practitioner is responsible for arranging for the attendance of his witnesses.

10.3 HEARING COMMITTEE

The hearing is held before a hearing committee composed of either a hearing officer, arbitrator, or panel of at least five individuals. Unless otherwise directed by the MECLG, the Superintendent and the Hospital Clinical Director determine the type of hearing committee and select the individual(s) to serve on the committee.

10.3.1 Panel members may not have participated in initiating the complaint or investigating the complaint or in committee consideration of the underlying matter at issue.

10.3.2 If a hearing officer is used, he shall be an attorney with expertise in medical staff privileges disputes who has not advised the hospital on the adverse recommendation.

10.3.3 If an arbitrator is used, he shall have experience in medical staff privileges disputes and must be acceptable to both the practitioner and the Superintendent.

10.3.4 If a panel is used, the panel members shall be selected from the medical staff. Non-staff practitioners may be used if particular expertise is needed or the panel cannot be appointed from the active, associate, or consulting staff. A member of the panel shall be appointed by the Superintendent to serve as the presiding officer. If a hearing officer is used in conjunction with a panel, the hearing officer shall serve as the presiding officer, may participate in deliberations and provide legal advice to the panel, but may not vote.

10.4 BURDEN OF PROOF

In the hearing, the representative(s) of the body issuing the adverse recommendation shall first present any evidence in support of the recommendation. The hearing committee and practitioner (or his representative) may question the representative(s) and any witnesses. The practitioner (or his representative) shall then present any evidence against the recommendation and shall have the burden of proof to persuade the hearing committee that there is not sufficient evidence to support an adverse recommendation or that an adverse recommendation would be unreasonable, arbitrary, capricious, or discriminatory. The hearing committee and the body's representative may question the practitioner and any witnesses.

10.5 RECORD OF THE HEARING

A court reporter selected by the hospital shall make a record of the

hearing. The cost of attendance of the reporter shall be borne by the hospital, but the cost of obtaining a copy of the transcript shall be borne by the requesting party.

10.6 PRESENCE OF PRACTITIONER

The personal presence of the practitioner who requested the hearing shall be required. Except in the case of illness or emergency as determined by the Superintendent, a practitioner who fails to appear and proceed at such hearing shall waive any right to review in the same manner and with the same consequence as if the practitioner failed to request a hearing.

10.7 REPRESENTATION BY AN ATTORNEY

The practitioner shall be entitled to be accompanied by and represented at the hearing by an individual of the practitioner's choice. The practitioner must provide the Superintendent with the name of his representative and whether he is an attorney at least twenty days prior to the hearing. If the individual is an attorney, the body whose adverse recommendation initiated the hearing shall also be entitled to be represented by an attorney at the hearing.

10.8 PRESENTATION OF EVIDENCE AND RIGHT TO CROSS-EXAMINATION

10.8.1 Authority. The hearing or presiding officer shall provide participants in the hearing with a reasonable opportunity to present relevant oral and documentary evidence in an efficient and expeditious manner, and shall maintain proper decorum. The hearing or presiding officer shall be entitled to determine the order and procedure for presenting evidence and argument during the hearing, and shall have the authority and discretion to make all rulings on questions that arise during the hearing.

10.8.2 Evidence. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply. Any relevant evidence shall be admitted if it is the sort of evidence responsible persons are accustomed to relying on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing or presiding officer shall order that oral evidence be taken on oath or affirmation administered by any person designated by him and so authorized by state law.

10.8.3 Written Statement. Both the practitioner and entity that initiated the adverse recommendation shall have the right to submit to the hearing committee for consideration a written statement on any matters pertinent to the adverse recommendation within five

working days of the hearing being closed.

10.9 HEARING COMMITTEE RECOMMENDATION

10.9.1 Presence of Members and Vote. The members of the hearing committee must be present throughout the hearing and deliberations. If a member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the recommendation unless he certifies in writing that he has read the transcript of all proceedings that occurred in his absence prior to the deliberations. At least three members of a panel must be present to continue the hearing.

10.9.2 Deliberations and Adjournment. The hearing committee shall, at a convenient time, conduct deliberations outside the presence of the parties and court reporter. The committee shall recommend rejection, affirmation, or modification of the adverse recommendation. The affirmative vote of a majority of the members eligible to vote is required for a recommendation that is adverse. Upon conclusion of deliberations, the hearing shall be declared adjourned.

10.9.3 Recommendation. Within fifteen days after adjournment of the hearing, hearing committee shall issue its written recommendation, including a statement of its findings and the basis for the recommendation, and shall forward the recommendation together with the hearing record and all other documentation to the Superintendent.

10.9.4 Notice and Further Action. The Superintendent shall notify the practitioner of the hearing committee's recommendation and shall provide the practitioner with a copy of the hearing committee's written recommendation.

10.10 APPELLATE REVIEW

10.10.1 The hospital executive staff shall constitue the appellate review committee.

10.10.2 Scope of Review. Appellate review shall be limited to a recommendation as to the following:

10.10.2.1 Whether the procedures set forth in the medical staff bylaws regarding the hearing and any subsequent review were substantially complied with; and

10.10.2.2 Whether, based on the evidence in the record, the adverse recommendation is unreasonable, arbitrary, capricious, discriminatory, or without basis.

10.10.3 Procedures. The proceedings shall be in the nature of an appellate review, based on the record of the hearing, the hearing committee's recommendation, any subsequent review by the MECLG or Governing body, any written statements submitted, and such other material as may be accepted by the appellate review committee. New or additional matters not raised during the original hearing shall only be introduced at the discretion of the appellate review committee and if not available at the time of the hearing.

10.10.4 Statements. The appellate review committee may allow the practitioner and a representative of the entity who issued the adverse recommendation to personally appear and make brief oral statements in favor of their positions. Any party so appearing shall be required to answer questions put to him by the appellate review committee. Parties appearing may not be accompanied by legal counsel unless approved.

10.11 FINAL DECISION BY GOVERNING BODY

The recommendation of the appellate review committee shall be forwarded to the Governing Body. Within fifteen days after receipt of the appellate review committee's recommendation the Governing Body shall review the matter and issue a final written decision, including a statement of the basis of the decision. The Superintendent shall send a copy of the Governing Body's final decision, including a statement of the basis of the decision, to the practitioner.

11.1 IDENTIFICATION

There are elected and appointed officers of the medical staff.

11.1.1 Elected officers of the medical staff are:

a. President

b. President-Elect

c. Immediate Past President

11.1.2 Appointed officers of the medical staff are:

a. Hospital Clinical Director

b. Director of Medical Services

c. Supervising physicians

11.2 QUALIFICATIONS OF OFFICERS

Elected officers must be active members of the medical staff at the time of the election and must remain active members during their term in office. Failure to maintain such standing immediately creates a vacancy in the office involved.

11.3 ELECTIONS

The President-Elect is elected each year at the first medical staff meeting in June. Voting is by secret ballot. If no candidate receives a majority of votes, the candidate with the least votes is eliminated on successive votes until one candidate has a majority.

11.4 TERM OF OFFICE FOR ELECTED OFFICERS

Each elected officer serves a one-year term commencing on July 1, the first day of the medical-staff year.

11.5 REMOVAL OF ELECTED OFFICERS

11.5.1 An elected officer may be recalled from office when a majority of the active members determine that:

a. He has become unwilling or unable to perform the duties of the office; or

b. His policies and decisions are unacceptable; or

c. He is guilty of malfeasance of misfeasance.

11.5.2 The procedure for recall of an elected officer is:

11.5.2.1 At least 1/3 of the active members make a written request to the MECLG that a vote be taken at a Med. Exec. Committee meeting to remove an elected officer from his office. The reasons for the request are stated in writing.

11.5.2.2 When such a request has been received, the MECLG informs each member at least fourteen calendar days before a vote is taken.

11.5.2.3 Active members vote by written secret ballot at the next appropriate medical staff meeting.

11.5.2.4 A 2/3 vote in favor of recall shall constitute a sufficient majority to recall an officer from office. Recall is effective immediately. The office is then filled according to the provisions of Section 11.6.

11.6 VACANCIES IN ELECTED OFFICE

If there is a vacancy in the office of President, the President-Elect assumes the office of President. A special election for a new President-Elect is held at the next regularly scheduled MEC meeting. If there is a vacancy in the office of President-Elect, the President appoints a nominating committee within seven days, and elections are held for a new President-Elect at the next regularly scheduled MEC meeting.

11.7 DUTIES OF OFFICERS

11.7.1 President of Medical Staff

a. Acts in coordination with the HCD in matters of mutual concern;

b. Calls, presides at, and is responsible for the agenda of all MEC meetings;

c. Enforces the medical staff bylaws and rules and regulations and promotes compliance with procedural safeguards where corrective action has been requested or initiated;

d. Represents the views and policies of the medical staff to the Superintendent/CEO, HCD, and Governing Body;

e. Interprets hospital policy to medical staff members;

f. Serves as a voting member of the Governing Body;

g. Serves as a member of the hospital PI Council.

h. Serves as a member of the Med. Exec. Committee

Leadership Group (MECLG).

11.7.2 President-Elect

a. Maintains an action register for MEC meetings;

b. Acts as a facilitator for MEC meetings;

c. Serves as a member of the MECLG;

c. Carries out other duties as assigned by the President of the Medical Staff.

11.7.3 Immediate Past-President

a. Serves as a member of the MECLG.

b. Performs other duties as may be assigned by the President and/or the MEC.

11.7.4 Hospital Clinical Director

The Hospital Clinical Director has ultimate responsibility for all clinical matters in the hospital. He is the permanently appointed chairperson of the Medical Executive Committee Leadership Group and acts as liaison between the medical staff and the governing body. By virtue of his chairmanship of the Medical Executive Committee Leadership Group, he has direct input and responsibility for the clinical privileges of each individual on the medical staff. The HCD has ultimate responsibility for Medical Staff PI and for the PI of the rest of the hospital and is the permanent chairperson of the Performance Improvement Council which has hospital-wide membership. The HCD provides for monitoring of the professional performance of all persons with clinical privileges in the hospital by the fact that he is in the direct supervisory line of all physicians in the hospital and of the directors of the professional disciplines. The HCD is appointed and reappointed to the medical staff through the same procedures outlined in Article VI.

Qualification: Board certification in psychiatry by the American Board of Psychiatry and Neurology.

11.7.5 Director of Medical Services

The Director of Medical Services is appointed by the HCD and approved by the Governing Body. The Dir. of Medical Services is responsible, under the supervision of the HCD, for providing the diagnosis, treatment, and supervision of care in all non-psychiatric medical matters for patients at the Utah State Hospital and supervises all non-psychiatirc medical providers in the hospital.

Qualification: Board certification in internal medicine, family practice, surgery, or other primary-care specialty.

11.7.6 Supervising Psychiatrists

Act as direct supervisor of a specified portion of the medical staff.

12.1 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.1.1 Composition

The MEC is composed of all provisional, associate, and active members of the medical staff. The Hospital Superintendent or his designee attends each MEC meeting on an ex-officio basis without vote.

12.1.2 General Meetings and Minutes

12.1.2.1 The MEC has one general meeting per month and may meet more frequently if necessary.

12.1.2.2 General MEC meetings are presided over and conducted by the President of the Medical Staff or the President-Elect in the absence of the President.

12.1.2.3 Special meetings may be called at any time by active members of the Medical Staff by petition to the President of the Medical Staff or the HCD. Written or telephone notice to all members stating the purpose, place, date, and hour is made by those requesting the meeting by at least the day prior to the meeting.

12.1.2.4 Members of the MEC are expected to attend all general and special meetings and all meetings of committees of which they are members, unless excused. Members are required to maintain an attendance of at least 75% of all meetings.

12.1.2.5 A majority (51%) of the members of the medical staff constitutes a quorum at general and special meetings. A majority (51%) vote by those members in attendance is required to accept or reject an issue.

12.1.2.6 A permanent record of the proceedings is kept of all general MEC meetings, including findings, conclusions, recommendations, and actions, and is kept on file with the medical staff coordinator. An action register is kept with the minutes which specifies who will carry out assigned actions and when assigned actions will be reviewed and evaluated.

12.1.2.7 The President of the Medical Staff may act for the MEC between regularly scheduled meetings.

12.1.3 Functions Carried Out in General Meetings

a. Review QI issues as part of the Medical Executive QI Committee function.

b. Receive and act on reports of medical staff committees and other assigned activity groups.

c. Receive and act on reports from the HCD.

d. Receive referrals from the Clinical Risk Management Committee and provide consultation for same.

e. Review/Approve clinical programs.

f. Discuss ethical concerns.

g. Review/Approve hospital policy and procedure forwarded from the MEC Leadership Group.

12.1.4 Medical Executive Committee Leadership Group (MECLG)

12.1.4.1 Membership

The HCD is the permanently appointed Chairman of the MECLG and casts the deciding vote when issues cannot be otherwise resolved.

The following individuals are voting members of the MECLG:

- Hospital Clinical Director (HCD)
- President of the Medical Staff
- President-Elect
- Immediate Past President
- Director of Medical Services
- Supervising Physicians

Other individuals are invited to attend as appropriate.

12.1.4.2 Functions

a. Recommend action to the governing body in matters of medical-administrative affairs.

b. Make recommendations to the Superintendent/CEO and/or governing body through the HCD regarding the structure of the medical staff, the mechanisms to review credentials and delineate individual clinical privileges, and the review of quality improvement activities.

c. Recommend to the governing body action to be taken on appointments and reappointments to Active, Associate,

Consulting, and Provisional membership in the medical staff organization and clinical privileges to be granted;

d. Recommend to the governing body an organization for the QI activities of the medical staff and the mechanism used to conduct, evaluate, and revise such activities.

e. Take reasonable steps to promote ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and participation in corrective action or review of measures where warranted.

f. Recommend to the HCD and/or Superintendent/CEO the temporary suspension of the clinical privileges of any practitioner whenever the personal or professional conduct of that member jeopardizes or is reasonably likely to jeopardize the safety or best interests of a patient unless immediate action is taken, or constitutes a willful disregard of medical staff bylaws, rules and regulations, or hospital policies.

g. Review QI issues as part of the Medical Executive QI Committee function.

h. Receive and act on reports from medical staff committees and other assigned activity groups.

i. Represent and act on behalf of the medical staff in intervals between general meetings subject to such limitations as may be imposed by these bylaws.

j. Develop a mechanism by which medical staff membership may be terminated;

k. Support and participate as indicated in fair hearing procedures. Fair hearing procedures for active, associate, and other members of the medical staff who are also merited employees of the State of Utah consist of access to the State Grievance Procedure as established and outlined by the Utah State Department of Human Resource Management. Provisional and contractual members of the medical staff have the right to request an administrative hearing through the Office of Administrative Hearings, Department of Human Services.

l. Serve as the Continuing Medical Education Committee of the hospital.

12.1.4.3 Meetings and Minutes

The MECLG meets once a month or more often as necessary, with all voting members having the right to request of the HCD that a special meeting be convened. A permanent record of the proceedings of all MECLG meetings, including findings, conclusions, recommendations, actions, and evaluation of actions, is kept on file with the medical staff coordinator.

12.1.4.4 The HCD may act for the MECLG in between regularly scheduled meetings.

12.2 BYLAWS COMMITTEE

12.2.1 Function

The Bylaws Committee function is carried out during meetings of the MECLG.

12.2.2 Duties

a. Conduct reviews of the Bylaws and Rules and Regulations as necessary;

b. Receive and evaluate suggestions for changes to the Bylaws and Rules and Regulations;

c. Forward to the MEC recommendations for changes to the Bylaws and Rules and Regulations by the time of the next regularly scheduled MEC meeting.

d. Forward to the Governing Body recommendations for changes to the Bylaws and Rules and Regulations as approved by the MEC.

12.3 CREDENTIALS COMMITTEE

12.3.1 Composition

The Medical Staff Credentials Committee consists of two psychiatrists and one physician from Medical Services who are appointed by the HCD.

12.3.2 Duties

a. Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, and clinical privileges. Recommendations from appropriate services and peers are obtained and considered.

Action on the application for clinical privileges is withheld until information regarding licensure, specific training, experience, current competence, and current health status is

available and is verified.

b. Make recommendations regarding reappointment and/or renewal or revision of clinical privileges.

These activities include a reappraisal of current licensure, evidence of current health status, professional performance, judgment, and clinical/technical skills, as indicated by the results of QI activities and other reasonable indicators of continuing qualifications. Recommendations from appropriate services and peers are obtained and considered.

The committee may ask applicants or staff members under review to be present at meetings with reasonable notice.

If the decision of the committee on issues relating to the staff member's competence is not unanimous, a minority opinion is included in a report which is reviewed by the MECLG.

c. Hear the petition of members who request to appear before the committee when they feel a condition exists in the hospital which precludes their effectively carrying out their duties.

d. Investigate, review, and report on matters referred by the HCD or MECLG regarding the qualifications, conduct, or clinical competence of an applicant or member.

12.3.3 Meetings and Records

12.3.3.1 Credential committee meets as frequently as necessary to carry out their duties in a timely manner.

12.3.3.2 The credentials committee's actions are recorded in a separate record on each individual who requests clinical privileges.

12.3.3.3 Recommendations are forwarded to the MECLG by the Medical Staff Coordinator.

12.4 MEDICAL EXECUTIVE P.I. COMMITTEE

12.4.1 Function

The Medical Executive PI Committee function may be carried out during any regular scheduled meeting of the Medical Executive Committee or Medical Executive Committee Leadership Group.

12.4.2 Duties

a. Monitor and review Medical Staff PI activities.

b. Review hospital-wide PI activities as determined by the HCD, the Chairperson of the Medical Executive PI Committee, or individual members of the Medical Staff.

c. Forward recommendations to the Quality Resources Office or the PI Council regarding hospital-wide PI.

12.4.3 Meetings

The Medical Executive PI Committee meets monthly or a minimum of ten times a year.

12.5 OTHER COMMITTEES

Medical Staff is represented on each of the following hospital-wide committees and provides the chairperson as appropriate.

Infection Control Committee
Research Committee
Medical Records Committee
Suggestion Committee
Ethics Committee
P.I. Council
Environment of Care Committee
Utilization Review Committee
Pharmacy and Therapeutics Committee
Emergency Preparedness Committee
Clinical Safety Committee

12.5.1 Appointments

Medical staff members of hospital committees are appointed by the HCD and confirmed by the Superintendent/CEO.

12.5.2 Term

12.5.2.1 Committee members are appointed to serve for one year and may be reappointed to serve an additional consecutive one-year term.

12.5.2.2 Committee chairpersons serve a one-year term and may be reappointed to an additional one-year term.

12.5.3 Committee Duties

a. Maintain written policies and procedures describing how the committee will carry out its purpose and, upon approval of the governing body, implement these policies and procedures.

b. Meet no less often than ten times a year if on a monthly meeting schedule or meet regularly as scheduled.

c. Maintain permanent records of activities.

12.5.4 Minutes

12.5.4.1 The chairperson of each committee and subcommittee ensures that minutes are written for each meeting.

12.5.4.2 Minutes include name of committee; date, time, and location of meeting; members present, absent, or excused; old business; new business.

12.5.4.3 For each item discussed, the minutes reflect discussion, findings, conclusions, recommendations, and actions to be taken. An action register is kept with the minutes and reflects who will take what action and the date that the action will be reviewed and evaluated.

12.5.4.4 Distribution of committee minutes is to members. A report of any significant items in the minutes is given by the committee chairperson or physician committee member in Medical Executive Committee meeting.

12.5.5 Committees have the Authority to:

a. Review records and charts pertinent to the purpose of the committee.

b. Require, with due notice, the appearance before the committee of practitioners employed at the hospital who have information relevant to the purposes of the committee.

12.5.6 Accountability and Relationships

12.5.6.1. Committees are responsible to their chairperson.

12.5.6.2 Committee chairpersons are responsible to the MEC Leadership Group members and the HCD unless otherwise specified in these bylaws.

12.5.6.3 Committee chairpersons and secretaries are responsible for maintaining minutes of their committee meetings.

13.1 AMENDMENTS

13.1.1 Recommendations for proposed amendments to the Bylaws and Rules and Regulations may be considered at any regularly scheduled or special MEC Leadership Group meeting. A two-thirds vote in favor is required to adopt or amend the Bylaws and Rules and Regulations. A quorum (51%) of members is required for a vote to be taken.

13.1.2 The MECLG forwards to the MEC, via the MECLG minutes, recommendations for amendments to the Bylaws and Rules and Regulations. These recommendations are considered at the next regularly scheduled MEC meeting. A two-thirds vote in favor is required to adopt or amend the Bylaws and Rules and Regulations. A quorum (51%) of members is required for a vote to be taken.

13.2 ADOPTION

These bylaws and the rules and regulations and amendments become effective when adopted by the medical staff and approved by the governing body.

ADOPTED BY THE MEDICAL STAFF
ON_____.

_____
PRESIDENT OF MEDICAL STAFF

_____
HOSPITAL CLINICAL DIRECTOR

APPROVED BY THE GOVERNING BODY
ON_____.

_____
SUPERINTENDENT

_____
DIRECTOR, STATE DIVISION OF MENTAL HEALTH

/ea
12/87
Revised: 1/89, 5/92, 6/93, 6/94, 9/94, 7/95, 8/96, 9/97, 2/98, 1/01, 9/01, 3/02, 8/02, 4/04

RULES AND REGULATIONS OF THE MEDICAL STAFF

The Medical Staff adopts such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations are a part of the bylaws and may be amended at any regular meeting of the Bylaws Committee by a two-thirds vote of a quorum (51%) of the active staff members. Such amendments become effective when approved by the Governing Body.

A copy of the rules and regulations is given to each physician, dentist, and podiatrist at the time of application for membership on the medical staff and for clinical privileges and to all members following amendment. All members of the medical staff are subject to the bylaws and rules and regulations and are subject to review of their clinical competence as part of the hospital quality improvement program.

At Utah State Hospital, the Operational Policies and Procedures establish the hospital's basic policies and rules and regulations. Each member of the medical staff is expected to comply therewith as a condition of his or her continued employment at the hospital. Any individual who is a member of the medical staff and who has been granted delineated clinical privileges is permitted to provide any type of care necessary as a life-saving measure or to prevent serious harm regardless of the staff status or specific clinical privileges provided that the care provided is within the scope of the individual's license.

Active participation in the medical staff committees when appointed is an obligation of each member. Failure to participate without a valid reason may be grounds for corrective action.

A. A physician is assigned as the psychiatric officer of the day (POD) to provide psychiatric care of patients as indicated.

B. The Hospital Clinical Director or his/her appointee has the responsibility of making a monthly schedule of physicians available for this coverage.

C. POD duty rotates among the psychiatric staff. The rotation is nondiscriminatory. POD duty is a privilege, not a right.

D. The POD works in collaboration with the medical officer of the day and the administrative officer of the day.

E. Call is from 4:00 PM to 8:00 AM on weekdays and from 8:00 AM to 8:00 AM on holidays and weekends. The POD is available by phone and/or beeper during these hours.

F. Requests for orders for seclusion and restraint are called to the POD after hours unless other arrangements have been made.

G. The POD completes the initial psychiatric assessment on weekend admissions when the patient is admitted prior to 12:00 noon on a day prior to a normal working day. The attending psychiatrist completes the initial psychiatric assessment the next day on patients admitted after 12:00 noon on Sunday.

H. Vacations are not covered by the POD. A physician going on vacation arranges coverage for the entire vacation period prior to the beginning of the vacation. When physicians take a vacation, they notify the Hospital Clinical Director and Supervising Physician in advance of their vacation and also indicate who will be covering their duties while they are gone. It is not the responsibility of the POD to make daily progress notes, etc. This should be done by the pre-selected physician who is covering the vacation.

I. The POD does not cover seclusion and restraint orders during the hours of 8:00 AM to 4:00 PM. If the attending physician cannot be reached within one-half hour, his supervisor is called.

J. The POD does not cover emergent responsibilities for physicians who are ill. If a physician is ill, he notifies his supervisor who will arrange coverage.

For further description of the POD duties and responsibilities, see the Utah State Hospital Operational Policy and Procedure (USHOPP) Manual.

A. A physician or nurse practitioner is assigned as the medical officer of the day (MOD) to provide medical care to patients as indicated.

B. Medical Services is responsible for providing a monthly schedule of personnel for this coverage.

C. The MOD works in collaboration with the POD and the administrative officer of the day.

Patients are admitted to the hospital by a psychiatrist on the active, associate, or provisional staff, either the Unit Clinical Director, staff psychiatrist, or POD.

A. The admitting psychiatrist is responsible for writing medical orders as necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient might be a source of danger for any reason.

B. The physician writes orders for appropriate observation and treatment of patients known or suspected to be potentially suicidal.

C. The Director of Medical Services is responsible for the non-psychiatric medical care of patients. The Director of Medical Services is a resource to the Unit Clinical Directors. Nurse practitioners have privileges as recommended by the Nursing Credentials Committee, in agreement with the Director of Medical Services, and approved by the Medical Executive Committee and Governing Body.

D. Seriously ill patients are seen by a member of the Medical Services staff as soon as possible after notification. If a licensed nurse practitioner makes an evaluation of a patient who is seriously ill, the nurse practitioner immediately notifies his or her supervising physician of the findings.

E. A comprehensive psychiatric assessment and a comprehensive physical assessment are completed as soon as possible but no later than within 24 hours of the admission of a patient. When nurse practitioners perform medical histories and physical examinations, their findings and conclusions are endorsed by a qualified physician member of the Medical Services staff within fourteen days.

F. In the event of a hospital death, the Director of Medical Services or designee is responsible to sign the death certificate if authorized by the Utah State Medical Examiner's Office.

G. The unit psychiatrist is responsible for the psychiatric care of patients on his/her unit(s). In the absence of the unit psychiatrist, the POD or another psychiatrist with whom the attending psychiatrist has made

arrangements is responsible for psychiatric care on the unit. Holiday, weekend, evening, and night coverage is provided by the POD.

H. Members of the medical staff are expected to provide input into the performance evaluations of the professional staff, and other staff as appropriate and necessary, in their service area and are also expected to provide input into the performance evaluation of the administrative director and program director of their service area.

I. Dental assessments are completed on all treatment patients within thirty days of admission. The Unit Clinical Director or the Director of Medical Services or his designee may order a dental assessment for patients at any time who are hospitalized for treatment.

The dentist may give a local anesthetic such as a mandibular block prior to performing a dental procedure but is not permitted to give a general anesthetic to a patient.

J. The podiatrist must have a referral for treatment based on a written order of the Unit Clinical Director or the Director of Medical Services or designee prior to treating a patient. Typical care provided on such referral involves examination of the feet; treatment of corn, bunions, ingrown toenails, and athlete's foot; prescription of foot gear; applications for relief of foot ailments; and instruction on foot care.

A. CONTENT.

Physicians are responsible for the preparation of a complete and legible medical record for each of their patients. Its contents must be pertinent and current. This record includes identification data; admitting diagnosis; medical history; social history; nursing assessment; other assessments as appropriate; reports of procedures, tests, and their results; other reports such as consultation, clinical laboratory, and radiology services; final diagnosis; conclusions at termination of hospitalization; and continuity of care instructions.

The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress in relation to the treatment plan. Refer to Utah State Hospital Charting Manual Responsibilities for additional information.

Multidisciplinary treatment plans established for the individual patient must show evidence of physician involvement in and approval of these plans.

B. HISTORY, PHYSICAL, AND PSYCHIATRIC EXAMINATION

1. A physical examination is performed and recorded within 24 hours of admission to the hospital.

2. A medical history and review of systems are recorded within 24 hours of admission to the hospital. Outside records may be a part of the hospital record.

3. A comprehensive psychiatric assessment is recorded within 24 hours of admission. Additional relevant information may be recorded in a progress note or dictated as an addendum to the psychiatric assessment, with the date obtained, as more information is obtained from the patient or significant others.

C. PROGRESS NOTES.

1. Progress notes must contain assessments of the patient's progress in accordance with the original or revised treatment plan. Progress notes must also contain recommendations for revisions in the treatment plan as indicated.

2. Progress notes are written each time a medication order is written or a substantial change in the patient's condition occurs but no less often than weekly for the first eight weeks after admission and every thirty days thereafter.

3. The attending psychiatrist's progress notes will include a section at least monthly which describes the doctor's awareness of and interventions in the patient's care including psychosocial needs and responses to medications.

D. CONSULTATIONS/REFERRALS/REPORTS

1. Consultations show evidence of review of the patient's record by the consultant and pertinent findings on examination of the patient, with the consultant's opinion and recommendations. This report is part of the patient's medical record.

2. Consultants' reports must contain a legible summary and recommendations.

E. CLINICAL ENTRIES.

1. Physicians must date, indicate the time of, and sign the initial psychiatric assessments, physical examination, physician's orders, his own progress notes, discharge summaries, and other documents as appropriate.

2. Symbols and abbreviations may be used only when they have been approved by the Medical Records committee. The list is updated and approved annually. An official record of approved abbreviations is kept on file in the Medical Records Department and on all patient-care units.

3. Diagnoses are recorded in full without the use of symbols or

abbreviations and are dated and signed by the responsible physician.

4. In all instances the contents of the medical records are sufficient to justify the diagnosis and warrant the treatment and end result.

F. DISCHARGE SUMMARY.

1. Charts of discharged patients must be turned into the Medical Records office within fifteen days. The physician's discharge summary and all other parts of the record are completed within thirty days of discharge. All records not so completed and filed within thirty days will be considered to be delinquent.

2. Each discharge summary is reviewed and authenticated by the responsible psychiatrist who dictates the hospital course and medications.

3. The summary includes current functioning; course in hospital; final DSM diagnosis (fives axes) and recommendations for follow-up.

G. CONFIDENTIALITY.

1. Written consent of the patient or legal guardian is required for release of medical information to persons not otherwise authorized to receive such information.

2. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute, as approved by the State Attorney General. All records are the property of the hospital and may not otherwise be taken without permission of the Superintendent of the hospital. In the case of readmission of a patient, all previous records are available for use of the physician. Unauthorized removal of charts from the hospital is grounds for suspension of a practitioner for a period to be determined by the Superintendent.

3. Research Projects/Publications. No member of the medical staff may undertake any type of research project within the jurisdiction of the hospital without first obtaining approval from the Research Committee. All requests for permission to publish scientific papers, books, or reports and photographs arising out of work performed at the Utah State Hospital must be in writing, stating the specific purpose for which the material will be used and must be approved by the Superintendent.

No member may offer for publication or newspaper release any scientific paper, book, or report arising out of work done at the Utah State Hospital without first securing approval of the Superintendent. All publications arising out of the work done in this hospital must

give credit to the hospital. A copy of each article or book approved for publication must be furnished to the Utah State Hospital Librarian for inclusion in the staff library.

H. FILING.

A medical record may not be permanently filed until it is completed by the responsible physician or is ordered filed incomplete by the Medical Records Committee.

I. COMPLETION.

1. The patient's medical record must be completed within the time frames listed above, including progress notes, final diagnosis, discharge summary, and authentication of all entries.

2. Prior to being absent from the hospital for five working days or longer, physicians are expected to complete all charts and are expected to notify the Hospital Clinical Director of their anticipated absence and their expected date of return.

SECTION VI. GENERAL CONDUCT OF CARE.

A. ORDERS FOR TREATMENT.

1. All orders for treatment must be documented in the medical record.

Orders which are illegible or improperly written will be clarified by nursing staff before being carried out.

2. Only registered nurses and nurse practitioners are authorized to accept telephone orders.

3. All medications administered to patients must be those listed in the current edition of the American Hospital Formulary Service. Medications for bonafide clinical investigations may be exceptions. They must be used in full accordance with the statement of principles involved in the use of investigational medications in hospitals and all regulations of the FDA.

Medications and other remedies may be recommended for purchase by the Pharmacy and Therapeutics Committee.

B. SPECIAL TREATMENT PROCEDURES.

1. All orders and procedures for the use of restraints and/or seclusion must follow the hospital policies and procedures in the USHOPP Manual.

2. Electroconvulsive therapy candidates are referred to an off-campus JCAHO-accredited provider.

3. Psychosurgery is not practiced at Utah State Hospital, nor is behavior modification with adversive conditioning.

A. Consultants are members of the medical staff except where otherwise specified.

B. Consultations among staff members are encouraged for the following:

1. Patient is a significant medical or surgical risk;

2. Diagnosis is obscure;

3. There is doubt as to the best therapeutic measures to be utilized.

C. An adequate investigation of the consultant's credentials and documentation of his privileges in other institutions is conducted prior to the signing of the contract either by hospital administration or the governing body.

A. House staff is defined as physicians licensed to practice medicine in Utah who are referred from the University of Utah or other approved psychiatric residency or fellowship training program.

B. House staff are supervised in their patient-care responsibilities by a physician(s) who has been granted clinical privileges through the medical staff process.

C. House staff practice within the scope of delineated clinical privileges of their physician supervisor(s).

D. Child and adolescent residents may write patient-care orders. Residents on Forensic, Geriatric, and Adult Services do not write patient-care orders or make patient-care decisions independently.

E. Progressive involvement of forensic, geriatric, and adult residents with patients and progressive independence of child and adolescent residents in patient care activities are subject to the discretion of the supervisor based on observation of the program participant's performance.

F. Properly supervised house staff may provide emergency care as described under article 3.4.c of these bylaws.

G. The supervisor communicates with the program director(s) as needed regarding problems with residents' performance, and an evaluation is submitted at the end of the rotation.

H. Prior to each Governing Body meeting, the program director(s) is invited to submit a report regarding the quality of education that residents are felt to be receiving at Utah State Hospital. The report is submitted to the Governing Body for consideration.

I. Medical and professional staff members have the option of not participating in the teaching program without jeopardizing their privileges.

ADOPTED BY THE MEDICAL STAFF
ON_____

_____
CHAIRMAN, MED. EXEC. COMM. LEADERSHIP GROUP

_____
PRESIDENT OF MEDICAL STAFF

APPROVED BY THE GOVERNING BODY
ON_____

_____
HOSPITAL SUPERINTENDENT

_____
DIR., DIV. OF MENTAL HEALTH

/ea 12-87
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